

**CONNECTICUT STATE DEPARTMENT OF EDUCATION
BUREAU OF SPECIAL EDUCATION
DUE PROCESS UNIT
P. O. Box 2219-Room 364
Hartford, Connecticut 06146-2219
FAX# (860) 713-7153**

Request For Mediation

While not required, the requested information will assist this office in scheduling the mediation.

We request a mediation concerning _____, _____
(name of child) (date of birth)

(address of child) (district/name of school) (child's disability)

Parent Signature Date District Signature Date

Parent email District email

Parent Telephone # District Telephone #

Description of the nature of the issues in dispute, including related facts:

Proposed resolution of the issues to the extent known and available at this time.

Please provide three **mutually** agreeable dates for the mediation, which will be held within 30 days of this request. From these dates, one will be selected for the convening of the mediation.

****Please forward to the above address and, as appropriate, the parents or the school district.****